single most important method of slowing the spread of HIV within populations, with mathematical modelling indicating that eliminating high infectivity in early infection has more effect than at any other disease stage.[5]

Thus, the diagnosis of PHI in at-risk individuals has considerable advantages in both individual and public heath terms. These two cases demonstrate how easy it can be to disregard such patients as having factitious HIV infection and are a gentle reminder that a negative antibody test does not necessarily exclude PHI. Healthcare professionals must continue to be alert to the less common clinical manifestations of PHI, be aware of the particular assays used in their own laboratory, and because no combination of symptoms is 100% sensitive or specific, diagnostic procedure must be broad and inclusive.[6]

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doi: 10.1136/sti.2004.013300

Accepted for publication 3 November 2004

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Complementary therapy and genital warts

Complementary therapy (CT) is now the second biggest growth industry in Europe (after IT). Up to 20% of the UK population visit a complementary therapist each year and as much as £5 billion is spent annually on such therapies.[1] In the United States this figure is $30 billion. The National Institutes of Health in the United States are keen to fund good scientific studies showing efficacy of CT, in order to ''disseminate authoritative information to the public and professionals''.[2] Objective data gathering is all the more important as a large majority of physicians view CT very negatively.[3]

Five years ago we were approached by a group of Reiki therapists to undertake a study showing the efficacy of Reiki healing on STIs. Reiki healing (RH) is a hands-on healing method that may be undertaken as distance healing.[4] There is a precedent for CT therapies being used in the form of yoga for patients with infection—in particular a well designed randomised trial showing efficacy in tuberculosis.[5] In view of this we undertook a study of the effect of RH at a distance on genital warts. The study had local ethics committee approval.

Patients with anogenital warts who were awaiting surgical treatment initially had their wart size and number assessed by a nurse using standard techniques.[6] Waiting time from this point to surgical removal of the warts averaged 6 weeks (plus or minus 1 week). Another nurse, who was blind to the initial wart visualisation, photographed the back of patient's head and then allocated each patient to a treatment (RH) or no treatment group according to a random code .Twelve Reiki healers were then each sent the photographs and undertook RH on them at a distance on a daily basis for about 10 minutes. Thus, half the patients received RH and the other half did not. Just before surgical removal of the warts the size and number of the warts was again assessed by the original nurse.

Considering a difference between a 35% reduction in wart volume for the Reiki treated group and a 10% reduction for the placebo (90% power 0.05) it was considered that 130 patients would be needed (65 in each arm); in fact, only 27 patients were enrolled into the study. Ten were lost to follow up .Of the 17 who completed the study nine received RH and eight did not. Two patients who received RH and one who did not totally cleared their warts. Seven who received RH and two who did not had an increase in wart mass/number. No patient who received RH and five who did not showed some degree of decrease in wart mass/number. These rates of regression are similar to those described in the placebo arms of recent double blind trials.[7 8]

Although this is a small study, we believe it was well designed but we failed to enrol large enough numbers. We also think it failed to show any efficacy for RH. Undertaking well designed trials of CT in the STI arena is important—not least because a majority of patients attending STI clinics may already be using them, and open discussion about them can help patients to make informed decisions as well as avoid drug interactions.[9]

In terms of common skin warts, efficacy of Reiki healing has not been shown to be effective.[10]

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doi: 10.1136/sti.2004.013912

Accepted for publication 9 November 2004

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Chlamydia trachomatis PCR positivity and inflammatory changes on cervical cytology

The presence of genital infection does not increase the likelihood of an inadequate Papanicolaou (Pap) test.[1] Conversely, testing for *Chlamydia trachomatis* at the time of routine cytological screening presents an opportunity to detect asymptomatic genital tract infection.[2] The PreservCyt fixative fluid (Cytyc Corporation, Boxborough. MA, USA) used for the ThinPrep Pap test (Cytyc Corporation) can be used for detection by the polymerase chain reaction (PCR) of *C trachomatis*.[3 4] This presents an opportunity to study the correlation between the chlamydia result and the Pap test finding.

We retrospectively reviewed all routine requests for chlamydia PCR on ThinPrep samples sent to our laboratory over a year. Data were collected on the woman's age, chlamydia PCR result, result of genital tract cultures if performed on the same date, and Pap test result. Data on the Pap test result included presence or absence of an epithelial cell abnormality either high grade (HGEA) or low grade (LGEA), whether the Pap was inflammatory and the presence or absence of recognisable pathogens. Cervical specimens collected in PreservCyt transport medium were processed for *C trachomatis* using the automated Cobas Amplicor (Roche Diagnostic Systems) and the method by Bianchi *et al*.[3]

Over the study period, 733 samples were received, of which 23 (3.1%) had *C trachomatis* DNA detected by PCR. Comparison of the women with chlamydia infection, with those without chlamydia infection is shown in table 1. There was no statistical difference in the presence of high or low grade epithelial abnormalities, recognition of other pathogens, or age of the women; however, 26% of women with chlamydia had an inflammatory Pap test compared to 9% of women without chlamydia ($p<0.01$).